Department of Veterans Affairs **VHA DIRECTIVE 2005-009**
Veterans Health Administration
Washington, DC 20420 **March 7, 2005**

UTILIZATION MANAGEMENT POLICY

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy for VHA's Utilization Management (UM) Program.

2. BACKGROUND

a. VHA Directive 96-048 decentralized VHA's UM Program and targeted inpatient utilization related to VHA medical care costs. This directive created the expectation that all admissions would be subject to a review against standardized criteria prior to admission. This directive also facilitated the structural transformation of VHA from a predominately inpatient focus to the present emphasis on outpatient care. In 2002, the Under Secretary for Health formed a committee to re-establish a national standardized UM policy, resulting in VHA Directive 2002-012, interim guidance for maintaining VISN UM programs.

b. In 2004, the Under Secretary for Health required VHA to establish a standardized national UM Program (see Att. A) so that VHA would have a consistent policy and national data that could be analyzed and used for ongoing quality improvement purposes. UM represents the overall program used to increase efficiency and appropriateness with which services are provided and resources are utilized (underutilization as well as overutilization). UM includes Utilization Review (UR) activities such as admission reviews and concurrent reviews. It is anticipated that VHA's UM plan will evolve to include utilization reviews across the continuum of care (e.g., outpatient activity, specialty referrals, imaging and procedure requests). Networks are encouraged to explore all settings in order to gain experience in anticipation of expanded utilization review requirements.

c. **Definitions**

(1) **Acute Admissions.** Acute Admission is a level of health care in which the patient's severity of illness and intensity of service can only be performed in an inpatient setting.

(2) **Admission Review.** The Admission Review is an assessment of medical necessity and appropriateness of a hospital admission after the hospitalization has occurred. This review is typically performed on admission, within 24 hours following the admission, or no later than the first business day following the admission. Standardized review criteria must be used to determine the appropriateness of care.

(3) **Alternate Level of Care.** The alternate level of care is alternative care that would have been more appropriate for a patient who did not meet the criteria for acuity or the admitted proposed level of care, had it been available. Possible alternatives include residential, outpatient services, home care, hospice, rehabilitation, observation, and others as defined by the facility.

(4) **Concurrent Review (Continued Stay Review).** Concurrent Review is an assessment that determines medical necessity or appropriateness of services during a patient's hospital stay or course of treatment, such as an assessment of the need for continued inpatient care for hospitalized patients. Concurrent reviews include continued-stay authorization and discharge review.

(5) **Data Analysis.** Data analysis is the study or assessment of trends in health and healthcare use. It is based on the collection of information designed to facilitate performance improvement.

(6) **Denial Management.** Denial management is a process where all denied claims are appropriately appealed or declared uncollectible and reported in a manner that provides optimal information flow. It also includes a consistent approach to track and appeal denials and a reporting system that measures outcome and appeal status. Non-authorizing decisions may be based on medical appropriateness or benefit coverage.

(7) **Diagnosis Related Group (DRG).** DRG is a case-mix classification system that groups patients who are similar clinically in terms of diagnosis and treatment, and in their consumption of hospital resources, thus allowing comparisons of resource use across hospitals with varying mixes of patients.

(8) **Diversion.** Diversion is the status where patients are diverted to other medical facilities due to unplanned reasons such as unavailability of beds, needed services that could not be provided, staffing, etc.

(a) Full Acute Medical and/or Surgical Care Diversion. Full-Acute Medical and/or Surgical Care Diversion is the status where all medical and surgical patient admissions are restricted. This status includes ambulance diversion and restricting transfers from other VA facilities.

(b) Limited-Acute Medical and/or Surgical Care Diversion. Limited-Acute Medical and/or Surgical Care Diversion is the status where medical and surgical patient admissions are restricted but selective medical and surgical admissions are allowed (i.e., elective admissions, scheduled transfers from other VA facilities, etc.). This status may include ambulance diversion, the Intensive Care Unit (ICU) diversion, Cardiac Care Unit (CCU) diversion, and restricting transfers from other VA facilities.

(9) **High Cost.** High cost refers to an individual or group of patients that consume a significant amount of resources. Resources could be cost, time, or personnel related.

(10) **Level of Care.** Level of care refers to the continuum of care which includes various intensities of service levels such as acute, rehabilitation, sub-acute, Skilled Nursing Facility (SNF), Home Care and Outpatient Rehabilitation, etc. The selection of the appropriate care setting is based on the review of an individual patient's severity of illness, co-morbidities, and complications.

(11) **Medical Care Group (MCG).** The MCG is a group of VA hospitals that are similar in size and complexity.

(12) **Observation Beds**. An Observation Bed is an alternate level of health care comprising short stay encounters for patients who require close nursing observation or medical management. It is an area where the patients are observed and assessed following surgery, during treatment, or provided to determine if they need to be admitted to the hospital. This may take up to 24 hours at which time a decision is required whether to send the patient home or admit the patient to the hospital.

(13) **Over Utilization.** Over utilization is when services were provided and the provision of services was indicated in either excessive amounts or in a higher-level setting than required.

(14) **Pre-admission Review.** The Pre-admission Review is a review performed prior to a scheduled (elective) admission. Pre-admission cases need to be reviewed for level of care and medical necessity.

(15) **Prospective Review.** A Prospective Review is the assessment of the appropriateness of an admission prior to a patient's admission, service, or course of treatment. Established review criteria must be used to determine the appropriateness of care. Prospective reviews include pre-authorization for inpatient and/or outpatient services.

(16) **Readmission Rate.** Readmission Rate refers to the ratio of patients re-admitted to the same or different hospital within 30 days following hospital discharge compared to the total number of patients discharged. Percentage needs to be based on a standardized denominator of per 100 bed days of care.

(17) **Retrospective Review.** A Retrospective Review is a review conducted after services have been provided and the patient has been discharged. Retrospective reviews include retroactive-reimbursement reviews, denial management, appeals, and UR data analysis.

(18) **Underutilization.** Underutilization is the failure to provide appropriate or indicated services or provision of an inadequate quantity or lower level of services than required.

(19) **Utilization Management (UM).** UM is the process of evaluating and determining the coverage and the appropriateness of medical care services across the patient healthcare continuum to ensure the proper use of resources.

(20) **Utilization Review (UR).** UR is a formal evaluation (prospective, concurrent, or retrospective) of the coverage, medical necessity, efficiency, or appropriateness of health care services and treatment plans for an individual patient**.**

(21) **Utilization Review Criteria**. UR Criteria is a set of measurable, clinical indicators, as well as diagnostic and therapeutic services reflecting the need for hospitalization or treatment. Appropriateness is based on patient's severity of illness and intensity of service being provided.

3. POLICY: It is VHA policy that VHA VISNs and facilities implement a standardized UM plan that encompasses the actions and tracking requirements documented in Attachment A.

4. ACTION

a. **VISN Director.** The VISN Director is responsible for:

(1) Ensuring that the national standardized UR Criteria, as approved by the National Leadership Board, is supported locally at each facility, without modification.

(2) Developing and publishing a VISN UM plan that:

(a) Addresses the domains of Cost, Quality, and Access.

(b) Delineates the responsibility, structure, and functions of UM in the VISN.

(c) Includes a standardized process for establishing inter-rater reliability and training for any criteria being used.

(d) Includes a process for analyzing UR data and developing appropriate performance improvement initiatives at the facility level.

(3) Ensuring each facility implements the Network plan and the mandated standardized components of the National UM policy no later than June 30, 2005.

(4) Developing, implementing, and providing facility oversight for a UM Plan that includes the appropriate requirements and standards for each facility (see subpar. 4b). ***NOTE:*** *Attachment A identifies data sources that may be used.*

b. **Medical Facility Directors.** Medical Facility Directors are responsible for ensuring:

(1) Compliance with the established nationally approved UR requirements listed in Attachment A and with the VISN UM Plan requirement.

(2) Random admission reviews on a minimum of 20 percent, or at least 30 cases, per month of all acute care admissions.

(3) All insurance and non-VA care cases per established VHA and insurance company guidelines and standardized criteria are reviewed.

(4) Additional admission VISN-selected high-cost patients, selected diagnoses, and high and low outliers are reviewed. ***NOTE:*** *This could include all admitted acute 1-day stays, observation stays, and unplanned readmissions within 30 days of a previous discharge.*

(5) A minimum of 20 percent, or at least 30 cases, of all inpatient stays per month are reviewed concurrently. Concurrent reviews on these cases will begin on the third day after admission and every third day thereafter, unless more frequent reviews are clinically indicated.

(6) Utilization reviewers are to be licensed health care professionals possessing advanced clinical knowledge, communication skills, and management abilities who have received appropriate training in standardized criteria. ***NOTE:*** *UR or UM Certification is highly recommended.*

(7) UM staff who are not licensed health care professionals, but are currently in these positions are grandfathered into these positions.

(8) The UM Plan includes a process for:

(a) Identifying over and under utilization.

(b) Identifying high cost patients that may benefit from case management.

(9) The collection and distribution of UM data according to Attachment A.

(10) The Chief of Staff appoints a designated and trained Physician Advisor.

c. **Physician Advisor.** The Physician Advisor, or designee, serves as the third-level reviewer within the facility, and is responsible for:

(1) Reviewing all cases not meeting standardized criteria referred by the UM and/or UR staff (First-lever Reviewer) after a Second-level Reviewer (Specialist or Attending Physician) variance.

(2) Providing recommendations to UM and/or UR staff, all of whom will have access to the Physician Advisor.

(3) Reviewing all denied services to ensure that appropriate care or services are not withheld due to compensation issues from third-party payers.

5. REFERENCES

a. OIG Report: Summary Review: Evaluation of Quality Management in VHA Facilities (Project No. 2003-00312-HI-0049).

b. National Committee for Quality Assurance (NCQA), Utilization Management Certification Standards and Guidelines, July 1, 2004.

c. Utilization Review Accreditation Commission (URAC), Health Utilization Management Standards, Version 4.2.0, 2004.

6. FOLLOW-UP RESPONSIBILITY: The Office of Quality and Performance (10Q) is responsible for the Quality Management oversight and implementation of this policy and the Chief Business Office (16) is responsible for Third Party Payment Reimbursement Utilization Review contents of this Directive. Questions are to be addressed to the Director of Risk Management at 202-273-8327, or the Chief Business Office at 202-254-0406.

7. RECISSIONS: VHA Directive 2002-012 is rescinded. This VHA Directive expires March 31, 2010.

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Attachment

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ATTACHMENT A

UTILIZATION MANAGEMENT TRACKING AND REPORTING TABLE

The Utilization Management (UM) Tracking and Reporting Table comprises of mandatory and discretionary UM and Utilization Review (UR) reporting variables for the Veterans Integrated Services Networks (VISNs) and the Department of Veterans Affairs (VA) medical centers. The following table outlines the frequencies for the reporting variables, the linked data sources, and appropriate distribution. ***NOTE:*** *The responsibilities for the data source extractions are included.*

***** Mandatory Reporting Variables (all other variables are highly recommended).

Variable	Data Source	Responsibility for Data Extraction	Reporting Frequency and Target Audience
1. * Number and percentage of VA admissions and continued stay days meeting criteria in Medicine, Surgery, and Behavioral Health for each medical center.	VISN and Facility UM Program	Medical Center	Quarterly to VA medical center management and VISN.
2. * Reasons for days not meeting criteria	VISN and Facility UM Program	Medical Center	Quarterly to VA medical center management and VISN.
3. * Recommended Level of Care when criteria not met	VISN and Facility UM Program	Medical Center	Quarterly to VA medical center management and VISN.
4. * Analysis of physician approval and/or denials of the number of patients not meeting criteria during the first level of review	VISN and Facility UM Program	Medical Center	Quarterly to VA medical center management and VISN.
5. * Acute Bed Day of Care Rate.	VISN Support Service Center (VSSC)	National data extract	Quarterly to VA medical center management and VISN.
6. Total Cost per unique patient per VISN.	VSSC; Decision Support System (DSS)	National data extract	Semi-annually to VA medical center management and VISN.
7. Thirty-day Readmission Rates for Medicine, Surgery, and Behavioral Health.	VSSC	National data extract	Quarterly to VA medical center management and VISN.

Variable	Data Source	Responsibility for Data Extraction	Reporting Frequency and Target Audience
8. Comparison of facility length of stay for VHA's top ten most frequent Diagnosis Related Group (DRG)'s	VSSC	VISN extract based on list provided by VHA	VHA will provide list semi-annually. Semi-annually for VISN.
9. Frequency of 1-day acute length of stay by services (Not Observation Level of Care).	VSSC	National data extract	Quarterly to VA medical center management and VISN.
10. High Cost Cases as determined by the VISN.	VSSC; DSS	VISN	To be determined by the VISN.
11. * Number of diversions and reasons for diversion	VA medical center Staff	Medical Center	Quarterly to VA medical center management and VISN.
12. Facility performance comparisons with the Medical Care Group (MCG) performance.	VSSC	Facility	To be determined by the facility.
13. Inter-rater reliability.	VISN and Facility UM Program	Medical Center	Quarterly to VA medical center management and VISN.